State/Territory: North Carolina

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

The following ambulatory services are provided.

(a) Chiropractic services
(b) Dental services
(c) Drugs, legend and insulin
(d) EPSDT
(e) Eyeglasses and visual aids
(f) Family planning services
(g) Hearing aids
(h) Optometric services
(i) Podiatry services
(j) Outpatient hospital
(k) Physician office visits
(l) Rural health clinics
(m) Free standing ambulatory surgical centers

Rural Health Clinic services are subject to limitations of the Physician's services program.

Other ambulatory services are subject to the limitations of each specific service program.

*Description provided on attachment.

State/Territory: North Carolina

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S):

1. Inpatient hospital services other than those provided in an institution for mental diseases.

X Provided: _ No Limitations X With Limitations*

2.a. Outpatient hospital services.

X Provided: _ No Limitations X With Limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise covered under the Plan)

X Provided: _ No Limitations X With Limitations*

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-PUB. 45-4).

X Provided: _ No Limitations X With Limitations

3. Other laboratory and x-ray services.

X Provided: _ No Limitations X With Limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

X Provided: _ No Limitations X With Limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

X Provided: X No Limitations _ With Limitations*

c. Family planning services and supplies for individuals of child-bearing age.

X Provided: X No Limitations _ With Limitations*

*Description provided on attachment.

State/Territory: North Carolina

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S):_____

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided: __ No Limitations X With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: __ No Limitations X With limitations:

*Description provided on attachment.

State/Territory: North Carolina

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): all

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

   a. Podiatrists' Services

      X Provided: _ No Limitations X With Limitations*

   b. Optometrists' Services

      X Provided: _ No Limitations X With Limitations*

   c. Chiropractors' Services

      X Provided: _ No Limitations X With Limitations*

   d. Other Practitioners' Services

      X Provided: _ No Limitations X With Limitations*

      Nurse Practitioner criteria described in Appendix 5 of Att. 3.1-A.

7. Home Heath Services

   a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

      X Provided: _ No Limitations X With Limitations*

   b. Home health aide services provided by a home health agency.

      X Provided: _ No Limitations X With Limitations*

   c. Medical supplies, equipment, and appliances suitable for use in the home.

      X Provided: _ No Limitations X With Limitations*

   d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

      X Provided: _ No Limitations X With Limitations*

*Description provided on attachment.

State/Territory: North Carolina

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): all

8. Private duty nursing services.

X Provided: __ No Limitations X With limitations*

9. Clinic services.

X Provided: __ No Limitations X With limitations*

10. Dental services.

X Provided: __ No Limitations X With limitations*

11. Physical therapy and related services.

a. Physical therapy.

__ Provided: __ No Limitations __ With limitations*

b. Occupational therapy.

__ Provided: __ No Limitations __ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

__ Provided: __ No Limitations __ With limitations*

12. Prescribed drugs, dentures, prosthetic devices and eyeglasses prescribed by a physician skilled in disease of the eye or by an optometrist.

a. Prescribed drugs.

X Provided: __ No Limitations X With limitations*

b. Dentures

X Provided: __ No Limitations X With limitations*

*Description provided on attachment.

State/Territory: North Carolina

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

c. Orthotic and Prosthetic devices.

X Provided: __ No Limitations X With limitations*

d. Eyeglasses.

X Provided: __ No Limitations X With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

X Provided: __ No Limitations X With limitations*

b. Screening services.

X Provided: __ No Limitations X With limitations*

c. Preventive services.

X Provided: __ No Limitations X With limitations*

d. Rehabilitative services.

X Provided: __ No Limitations X With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

X Provided: X No Limitations __ With limitations*

b. Skilled nursing facility services.

__ Provided: __ No Limitations __ With limitations*

*Description provided on attachment.

State/Territory: North Carolina

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

c. Intermediate care facility services.

__ Provided: __ No Limitations __ With limitations**

15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

X Provided: __ No Limitations X With limitations*

b. Including such services in a public institution (or distinct art thereof) for the mentally retarded or persons with related conditions.

X Provided: __ No Limitations X With limitations*

16. Inpatient psychiatric facility service for individuals under 21 years of age.

X Provided: __ No Limitations X With limitations*

17. Nurse-midwife services.

X Provided: __ No Limitations X With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

X Provided: X No Limitations __ With limitations*

*Description provided on attachment.

State/Territory: NORTH CAROLINA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S):

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: __ With limitations*

__ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z) (2)(F) of the Act.

__ Provided: __ With limitations*

X Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

+ ++

X Provided: X Additional coverage

b. Services for any other medical conditions that may complicate pregnancy.

+ ++

X Provided: X Additional coverage __ Not provided.

21. Certified pediatric or family nurse practitioners' services.

X Provided: __ No limitations __ With limitations*

__ Not provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

20. DESCRIPTION OF EXTENDED SERVICES TO PREGNANT WOMEN

Pregnancy related and postpartum services include:
Physician
Clinic, including rural health and migrant health
In-patient hospital
Outpatient hospital
Prescription drugs

The above services are provided to all Medicaid eligibles. The restrictions specified in ATTACHMENT 3.1-A.1 apply to all eligibles including pregnant women. Services available to pregnant women do not exceed the scope of services available to other eligible individuals or groups.

Childbirth Education Classes

Childbirth education classes include a series of classes which meets two or more times and provides instruction designed to prepare pregnant women and their support person for the labor and delivery experience. These classes should be based on a written plan which outlines course objectives and specific content to be covered in each session. Instruction includes, but is not limited to:

- important aspects of prenatal care, including danger signs
- signs of pre-term labor
- preparation for labor and delivery
- breathing and relaxation and other comfort measures

Instructors - certified childbirth instructors preferably, or registered nurses and other health professionals who have completed training designed to prepare them as childbirth instructors.

Parenting Education

Parenting education classes include a series of classes which meets two or more times and provides a total of at least six hours of instruction designed to help new parents, or parents to be, improve their skills and be more knowledgeable about carrying out their primary responsibilities as parents. These classes should be based on a written plan which outlines course objectives and specific content to be covered in each session. Instructions includes but is not limited to:

- caring for your new baby
- early growth and development
- early self-esteem
- injury prevention
- child health supervision

Instructors - Instructors include persons certified as parent or family life educators, early childhood developmental specialists, registered nurses or other health care providers who have completed training designed to prepare them as parenting instructors or facilitators.

Nutritional services

Nutritional Services, when provided by a qualified nutritionist to Medicaid eligible pregnant women identified as having high risk conditions by their prenatal care provider, includes but is not limited to:

- Nutrition Assessment
- Development of an individualized care plan
- Diet therapy
- Counseling, education about needed nutrition habits/skills and follow-up
- Communication with the WIC Program, Baby Love Program and prenatal care provider as appropriate.

The high risk indicators used to access the client's medical need for the services are as follows:

- diabetes or other metabolic disorder
- hypertension or other chronic condition
- anemia (Hgb<10gm/dl; hct<30%)
- < 15 years of age at time of conception
- multiple fetuses
- prescribed therapeutic diet
- inappropriate weight gain (inadequate, erratic, excessive)
- intrauterine growth retardation
- underweight at conception (<90% standard weight for height)
- very overweight at conception (>135% standard weight for height)
- eating disorder (pica, anorexia, bulimia)
- substance abuse (alcohol, drugs, tobacco)
- HIV infection
- hemoglobinopathies (sickle cell disease, thalasemia)
- other high risk medical conditions as referred by prenatal care provider.

State/Territory: North Carolina

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

_ Provided: _ No limitations _ With limitations*

X Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

X Provided: _ No limitations X With limitations*

b. Services of Christian Science nurses

_ Provided: _ No limitations _ With limitations*

c. Care and services provided in Christian Science sanitoria.

_ Provided: _ No limitations _ With limitations*

d. Skilled nursing facility services provided for patients under 21 years of age.

X Provided: _ No limitations X With limitations*

e. Emergency hospital services.

_ Provided: _ No limitations _ With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

X Provided: _ No limitations X With limitations*

State/Territory: North Carolina

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_ Provided X Not Provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

X Provided:
- _ State Approved (Not Physician) Service Plan Allowed
- _ Services Outside the Home Also Allowed
- X Limitations Described on Attachment

_ Not Provided

LIMITATIONS ON AMOUNT
DURATION AND SCOPE OF SERVICES
MEDICALLY NEEDY

Services covered for medically needy individuals are equal in amount, duration and scope to services covered for the categorically needy. Limitations are described in Attachment 3.1-A.1.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Medicaid Program: Requirements Relating to Covered Outpatient Drugs for the Medically Needy

12.a. PRESCRIBED DRUGS

Citation (s)	Provision (s)
USC 1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Medicaid Program: Requirements Relating to Covered Outpatient Drugs for the Medically Needy
12.a. PRESCRIBED DRUGS *continued*

Citation (s)	Provision (s)
USC 1927(d)(2) and 1935(d)(2)	The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D. (1) The following excluded drugs are covered: ☑ (a) Agents when used for the symptomatic relief of cough and colds All legend products that contain expectorants or cough suppressants. Examples are: expectorant/antitussive combination, antihistamine/decongestant/antitussive combination, antihistamine/decongestant/expectorant combination, antihistamine/decongestant/expectorant/antitussive combination, antihistamine/expectorant combination, antihistamine/antitussive, antitussive/decongestant/analgesic/expectorant, and antitussive/decongestant/analgesic ☑ (b) All legend vitamins and mineral products, except prenatal vitamins and fluoride ☑ (c) Non-prescription drugs North Carolina (NC) will only cover selected rebateable over the counter (OTC) products when not covered by the prescription drug plans (PDPs). Examples of OTC drugs covered are: Insulin products, non-sedating antihistamines e.g. Loratadine OTC and Claritin OTC, proton pump inhibitors e.g. Prilosec OTC.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Medicaid Program: Requirements Relating to Covered Outpatient Drugs for the Medically Needy

12.a. PRESCRIBED DRUGS *continued*

Citation (s)	Provision (s)
USC 1927(d)(2) and 1935(d)(2)	☑ (d) All Barbiturates ☑ (e) All Benzodiazepines ☑ (f) Agents when used to promote smoking cessation (non-duals only). NC will cover legend products the non-duals. NC will cover for the duals (when not covered by the PDPs) and non-duals selected rebateable OTC products. Some examples are: Nicoderm CQ, Nicotrol, Commit, and Nicorette Gum. (2) The following excluded drugs are not covered: (a) Agents when used for anorexia, weight loss, weight gain (b) Agents when used to promote fertility (c) Agents when used for cosmetic purposes or hair growth (d) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT Attachment 3.1-C
MEDICAL ASSISTANCE PROGRAM

State North Carolina

STANDARDS AND METHODS TO ASSURE HIGH QUALITY CARE

Institutional care will be provided by facilities qualified to participate in Title XVIII and/or Title XIX.

Physicians' services are those services provided within the scope of practice, as defined by State law, by or under the personal supervision of an individual licensed under State law to practice medicine, osteopathy, podiatry, and optometry. Those services, as required by State statute, performed by a licensed optometrist or podiatrist which fall within the scope of services performed by a doctor of medicine are the only podiatric and optometric services which may be covered.

Drugs will be provided only on the written prescription of a licensed practitioner qualified to prescribe and will be dispensed through registered or licensed pharmacies except for remote areas where pharmaceutical services are not available, except when dispensed by the physician.

Independent laboratories and x-ray facilities, including such facilities in a physician's office, furnishing outpatient diagnostic services must meet the standards prescribed for participation under Title XVIII.

Home health agencies must meet the standards prescribed for participation in Title XVIII.

Consultants in pharmacy, dentistry, nursing, and medicine, with advice and counsel of committees representing professional provider groups and advisory council, will participate in program planning, establishing standards, and program evaluations.

Provisions will be made for obtaining recommended medical care and services regardless of geographic boundaries.

Long term care of patients in medical institutions will be provided in accordance with procedures and practices that are based on the patient's medical and social needs and requirements.

Standards in other specialized high quality programs such as Crippled Children's Services will be incorporated as appropriate.

Rec'd 12/26/73 OPC-11# 73-45 Dated 12/21/73

R.O. Action 7/19/74 Eff. Date 10/1/73

Obsoleted by _____ Dated _____

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Limitations in the Amount, Duration and Scope of Certain Items of Provided Medical and Remedial Care and Services are Described Below:

CITATION	Medical and Remedial Care and Services	
42 CFR 431.53	**Item 24.a Transportation**	Methodologies for medically necessary ambulance transportation are found in Attachment 3.1-A.1, page 18. Transportation services for categorically needy are defined in Attachment 3.1-A and transportation services for medically needy are defined in Attachment 3.1-B. An amount to reimburse nursing facilities, ICF-MR and domiciliary care facilities for non-ambulance non-emergency transportation is included in Medicaid payments to those facilities. The county departments of social services, acting as agents of the State, purchase medically necessary non-emergency transportation to cover services for recipients residing in the county who do not live in a nursing facility, ICF-MR, or domiciliary care facility. They negotiate rates with local transportation providers, assuring that transportation appropriate to the recipient's needs is provided in the most cost effective method. This includes transportation for full benefit dual eligible recipients to obtain Medicare Part D covered drugs.

State/Territory: North Carolina

I. Coverage of Transplant Services

Subject to the specifications, conditions, and limitations established by the State Medicaid Agency, transplant services are covered as follows:

- Coverage is limited to transplant services that are specified in the North Carolina Division of Medical Assistance Medicaid Clinical Coverage Policies. Additionally, the criteria for determining a recipient's clinical eligibility for transplantation are specified in the Medicaid Clinical Coverage Policies as well. The North Carolina Division of Medical Assistance Medicaid Clinical Coverage Policies can be located on the web at www.dhhs.state.nc.us/dma/mp/mpindex.htm.

- Organs procured from outside the transplanting facility must be obtained from an organ procurement organization meeting the standards described in Section 1138 of the Social Security Act. The North Carolina Division of Medical Assistance Medicaid Clinical Coverage Policies further specifies organ procurement requirements. These policies are available on the Division's website located at www.dhhs.state.nc.us/dma/mp/mpindex.htm.

- The transplant facility must meet the requirements contained in Section 1138 of the Social Security Act.

- Donor expenses are covered for certain transplants as specified in the North Carolina Division of Medical Assistance Medicaid Clinical Coverage Policies that are available on the Division's website located at www.dhhs.state.nc.us/dma/mp/mpindex.htm.

State/Territory: North Carolina

II. Solid Organ Transplants

A. Medically necessary solid organ transplants and other related procedures are covered for adults and children, with prior approval. These include the following:

- Heart transplant
- Heart/lung transplant
- Lung transplant
- Liver transplant
- Kidney transplant
- Pancreas transplant
- Islet cell transplant
- Small bowel, small bowel/liver and multi-visceral transplant
- Ventricular assist device (VAD)
- Extracorporeal membrane oxygenation (ECMO), Extracorporeal life support (ECLS)
- Implantable cardioverter defibrillator (ICD)
- Biventricular Pacemaker for congestive heart failure (CHF)

State/Territory: North Carolina

B. Definitions

1. Cadaveric/deceased donor is a person who has been declared dead and his/her family has offered one or more organs to be used for transplantation or is a dying person that has self-declared that he/she will offer one or more organs to be used for transplantation.

2. Living donor is a living person who donates an organ or part of an organ to another person.

3. Xenotransplantation refers to the surgical transfer of cells, tissues or whole organs from one species to another.

State/Territory: North Carolina

C. Clinical Packet requirements for Prior Approval

All clinical transplant packets submitted for review should include the documentation delineated below. Incomplete clinical transplant packets will not be approved. Documentation should include:

1. Letter from recipient's physician requesting solid organ transplant and summarizing the recipient's clinical history.
2. All lab results including: Human Immunodeficiency Virus (HIV), Rapid Plasma Reagin (RPR), Hepatitis panel, Prothombin Time (PT), International Normalized Ratio (INR), infectious disease serology, inclusive of Cytomegalovirus (CMV) and Epstein-Barr Virus (EBV).
3. All diagnostic and procedure results.
4. Complete psychosocial evaluation with documentation of post-transplant care needs.
5. Psychiatric evaluation, if psychiatric history is documented.
6. Where the recipient has a history of substance abuse, completion of a substance abuse treatment program and sequential screenings for relevant substances. Specific requirements may be found in the Medicaid Clinical Coverage Policies for transplants located on the Division of Medical Assistance's website at www.dhhs.state.nc.us/dma/mp/mpindex.htm.
7. Any additional clinical documentation that is requested by the North Carolina Division of Medical Assistance and/or that is required by specific Medicaid Clinical Coverage Policies.

State/Territory: North Carolina

D. Other

- The NC Division of Medical Assistance will consider coverage for other transplants based on clinical trials reported in peer reviewed journals, new technology assessments and medical necessity.

- Additional information regarding solid organ transplantation medical coverage criteria and donor fees has been specified in the North Carolina Division of Medical Assistance Medicaid Clinical Coverage Policies. These policies are available on the Division's website located at www.dhhs.state.nc.us/dma/mp/mpindex.htm.

State/Territory: North Carolina

III. Stem Cell/Bone Marrow/Umbilical Cord Transplants

A. Medically necessary Stem Cell/Bone Marrow/Umbilical Cord transplants and other related procedures are covered for adults and children, with prior approval. Current stem cell transplants and related procedures include:

- High Dose Chemotherapy (HDC) +/- Total Body Irradiation (TBI) including autologous/allogeneic stem cell for acute lymphocytic leukemia
- HDC +/- TBI including autologous/allogeneic stem cell for acute myelogenous leukemia
- HDC +/- TBI including autologous/allogeneic stem cell for chronic myelogenous leukemia
- HDC +/- TBI including autologous/allogeneic stem cell for germ cell tumors
- HDC +/- TBI including autologous/allogeneic stem cell for Hodgkins disease
- HDC +/- TBI including autologous/allogeneic stem cell for Multiple Myeloma and Primary Amyloidosis
- HDC +/- TBI including /allogeneic stem cell for Myelodysplastic diseases
- HDC +/- TBI including /allogeneic stem cell for genetic diseases and acquired anemias
- HDC +/- TBI including autologous stem cell for Primitive Neuroectodermal Tumors (PNET) and Ependymoma
- HDC +/- TBI including autologous/allogeneic stem cell for Non-Hodgkins Lymphoma
- HDC +/- TBI including autologous for ovarian cancer and germ cell tumors arising in the ovaries
- HDC +/- TBI including autologous/allogeneic stem cell for solid tumors of childhood
- Placental and Umbilical Cord Blood as a source of stem cells
- Non-Myeloablative Allogeneic stem cell (Mini-Transplant, Mini-Allograft Reduced Intensity Conditioning) for the treatment of malignancies
- Donor Leukocyte, Donor Lymphocyte or Buffy Coat Infusion for hematologic malignancies that relapse or are at high risk for relapse after allogeneic stem cell transplant
- Photophresis for Solid Organ Rejection, Autoimmune Disease and Graft-Versus Host Disease (GVHD)
- Bone Morphogenic Protein-2 Allograft

State/Territory: North Carolina

B. Definitions

1. Autologous means the new marrow comes from the patient/recipient. The marrow or stem cells are collected, stored and reinfused to the patient/recipient.

2. Allogeneic refers to new cells which arise from an appropriately matched donor.

3. Bone marrow transplant means a technique in which bone marrow is transplanted from one individual to another or removed from and transplanted to the same individual in order to stimulate production of blood cells. It is used to treat malignancies, certain forms of anemia and immunologic deficiencies.

4. Stem cell transplant restores stem cells, also called peripheral stem cell. The donor can be related or unrelated. The stem cells used in peripheral blood stem cell transplantation (PBSCT) come from the bloodstream. A process called apheresis or leukapheresis is used to obtain peripheral blood stem cells (PBSCs) for transplantation.

5. Mini-transplant is a type of allogeneic transplant and uses lower, less toxic doses of chemotherapy and/or radiation. It may also be called a non-myeloablative or reduced-intensity transplant.

6. Tandem transplant is a type of autologous transplant. The patient/recipient receives two sequential courses of high-dose chemotherapy with stem cell transplant.

7. Umbilical cord blood transplant is the injection of umbilical cord blood to restore an individual's own blood production system suppressed by anticancer drugs, radiation therapy.

State/Territory: North Carolina

C. Clinical Packet requirements for Prior Approval:

All clinical transplant packets submitted for review should include the documentation delineated below. Incomplete clinical transplant packets will not be approved. Documentation should include:

1. Letter from recipient's physician requesting solid organ transplant and summarizing the recipient's clinical history.
2. All prior chemotherapy regimen and dates
3. All lab results including: HIV, RPR, Hepatitis panel, PT, INR, infectious disease serology, inclusive of CMV and EBV.
4. All diagnostic and procedure results inclusive of bone marrow aspiration.
5. Complete psychosocial evaluation with documentation of post-transplant care needs.
6. Psychiatric evaluation, if psychiatric history is documented.
7. Where the recipient has a history of substance abuse, completion of a substance abuse treatment program and sequential screenings for relevant substances. Specific requirements may be found in the Medicaid Clinical Coverage Policies for transplants located on the Division of Medical Assistance's website at www.dhhs.state.nc.us/dma/mp/mpindex.htm.
8. Any additional clinical documentation that is requested by the North Carolina Division of Medical Assistance and/or that is required by specific Medicaid Clinical Coverage Policies.

State/Territory: North Carolina

D. Other

- The NC Division of Medical Assistance will consider coverage for other transplants based on clinical trials reported in peer reviewed journals, new technology assessments and medical necessity.

- Additional information regarding stem cell/bone marrow/umbilical cord transplantation medical coverage criteria and donor fees has been specified in the North Carolina Division of Medical Assistance Medicaid Clinical Coverage Policies. These policies are available on the Division's website located at www.dhhs.state.nc.us/dma/mp/mpindex.htm.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE North Carolina

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

The following method is used to provide benefits under Part A and Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:

1. __ Individuals, receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   Yes __ No __

2. __ Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-a plan, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   Yes __ No __

3. X All individuals eligible under the State's approved title XIX plan.

4. __ Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

B. Part A group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

C. Payment of Part A and Part B deductible and coinsurance costs. Such payments are made in behalf of the following groups:

1. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

2. Categorically and Medically Needy

3.

TITLE VI
MONITORING REPORT

Name of Provider_____ Date of Visit_____
Address_____ Monitor's Name
City_____ State_____ Monitor's Title_____

Information Desired:

1. The use of signs:

_____

_____

2. Dual Facilities:

_____

_____

3. The Provider's policy with respect to the order of seeing patients:

__ Appointments Only
__ Walk-in Only
__ Appointments and Walk-in
__ Procedure for logging walk-in patients?_____

_____

Comments:_____

_____

4. Does the Provider have a policy regarding the use of courtesy titles?

_____

_____

ADDITIONAL COMMENTS: _____

_____

_____

_____

_____

Effective Date 10/1/75